August 28, 2003

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M2-03-1565-01

___ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). ___' IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ___ for independent review in accordance with this Rule.

___ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing physician on the ___ external review panel. This physician is board certified in anesthesiology. The ___ physician reviewer signed a statement certifying that no known conflicts of interest exist between this physician and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ___ for independent review. In addition, the ___ physician reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History
This case concerns a 39 year-old male who sustained a work related injury on ___. The patient reported that while at work he was on the fourth floor of a construction building when he slipped and fell. The patient reported experiencing immediate pain in his low back. The patient has undergone X-Rays of his lumbar spine, a CT scan of the lumbar spine on 4/30/02, an EMG/NCV on 7/25/02 and a myeolgram on 10/8/02. The diagnoses for this patient include lumbo-sacral joint dysfunction, sciatica/neuritis of sciatic nerve, fibromyositis/myalgia/myositis and depression. The patient has been treated with conservative treatment that has included physical therapy, therapeutic exercises, moist heat, e-stim, joint mobilization, myofasical release and Biofreeze analgesic gel. The patient was also referred to an orthpedist for evaluation on 4/16/02.

Requested Services
Chronic behavioral pain management program, five times per week for six weeks.

Decision
The Carrier's denial of authorization for the requested services is upheld.

Rationale/Basis for Decision
The ___ physician reviewer noted that this case concerns a 39 year-old male who sustained a work related injury to his back on ___. The ___ physician reviewer explained that the patient sustained a mild to moderate back sprain as a result of the work related injury on ___. The ___ physician reviewer indicated that there is not objective evidence indicating disc herniation or nerve compression by CT myelogram or EMG. The ___ physician reviewer explained that the

patient has not responded to medical therapy or chiropractic manipulation or traction. The ___ physician reviewer indicated that the patient appears to have mental health concerns. The ___ physician reviewer explained that the degree of depression does not seem to be consistent with the injury occurred. The ___ physician reviewer also explained that there was no head injury reported and there have been no objective neurologic findings to suggest this injury could be responsible for the change in this patient's baseline mental condition. The ___ physician reviewer indicated that the patient's mental health condition should be addressed prior to enrollment in any chronic pain management program. The ___ physician reviewer explained that the documentation provided does not shoe that a psychiatric evaluation has been performed. Therefore, the ___ physician consultant concluded that the requested chronic behavioral pain management program, five times per week for six weeks is not medically necessary to treat this patient's condition at this time.

This decision is deemed to be a TWCC Decision and Order.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10 (ten)** days of your receipt of this decision. (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20 (twenty)** days of your receipt of this decision. (28 Tex. Admin. Code 148.3).

This decision is deemed received by you 5 (five) days after it was mailed. (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing should be sent to:

Chief Clerk of Proceedings/Appeals Clerk
P.O. Box 17787
Austin, TX 78744
Fax: 512-804-4011

A copy of this decision should be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute. (Commission Rule 133.308(t)(2)).

Sincerely,

I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 28th day of August 2003.